ATTACH CHECK HERE	GEORGIA MEDICAL BOARD (GMB) USE ONLY			
	AP NUMBER		**FILE NUMBER**	
	RECEIVED		**COMPLETED**	
	LICENSE NUMBER		**DATE ISSUED**	
	WITHDRAWN		**DATE WITHDRAWN**	
	DENIED		**DATE DENIED**	

*** EFFECTIVE JULY 1, 2001 ALL FEES ARE NONREFUNDABLE***

F E E S A R E S U B J E C T T O C H A N G E

*Social Security information is authorized to be obtained and disclosed to state and federal agencies under the Georgia Child Support Recover Act, O.C.G.A.§ 19-11-1 et seq/, O.C.G.A.§ 20-3-295(student loan defaults), the Child Support Enforcement Act 42 U.S.C.A. § 651 et. seq. and the Higher Education Act of 1965, 20 U.S.C.A.§ 1001 et. seq. This information may also be disclosed to other licensing boards or regulatory agencies for license tracking purposes. If you do not wish this information to be released to other licensing boards or other regulatory agencies for license tracking purposes, please **check here____.** You will be contacted prior to releasing this information, when necessary.

BASIC INFORMATION – AURICULAR DETOXIFICATION SPECIALIST

1. US Social Security Number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

2. LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME

SEX M F		DATE OF BIRTH (MM/DD/YY)	

3. MAILING ADDRESS – This address will be used to mail application status information.

STREET NUMBER	STREET NAME		APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
( ) (AREA CODE) HOME PHONE NUMBER	( ) (AREA CODE) EMERGENCY PHONE NUMBER		@ E-MAIL ADDRESS

4. PRACTICE STREET ADDRESS – This address will appear on the internet.

STREET NUMBER	STREET NAME		SUITE #
CITY	STATE	ZIP CODE	COUNTY
( ) (AREA CODE) DAYTIME PHONE NUMBER	( ) (AREA CODE) BUSINESS PHONE NUMBER		

5. I/am have been certified/licensed to practice as a Auricular Detoxification Specialist by virtue of certification issued in another duly constituted licensing Board in the United States as follows (use additional pages if necessary)

STATE	DATE OF CERTIFICATION/LICENSURE	CERTIFICATE OR LICENSE NUMBER	ACTIVE/INACTIVE

APPLICANT QUESTIONNAIRE		
	YES	**NO**
6. Have you passed the CCAOM exam and received certification for the Clean Needle Technique Certification? Please contact the CCAOM and have them send proof of your certification directly to the Composite State Board of Medical Examiners.	❑	❑
<u>INSTRUCTIONS</u>: If you answer, "YES" to any of the following questions, you are required to furnish complete details, including an explanation, date, place, offense charged, plea, final disposition of the matter, name of court, state, count/jurisdiction (include any court orders or copies of malpractice suites if applicable).	❑	❑
7. Have you ever been arrested, convicted, sentenced, plead guilty, plead nolocontendere or been given first offender status for any offense other than a minor traffic violation? Please include any felony, any crime involving moral turpitude, any violation of state or federal laws regarding controlled substance or dangerous drugs, or any DUI offense.	❑	❑
8. Have you ever had your license to practice a business or profession in Georgia or any other state or country revoked, suspended, denied, annulled, refused to be renewed, or subject to disciplinary action?	❑	❑
9. To your knowledge, are you currently under investigation by any licensing board or agency as of the date of this application?	❑	❑
10. Have you ever voluntarily surrendered your certification or license?	❑	❑
11. Has your application for taking a licensing or certification examination ever been denied?	❑	❑
12. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years?	❑	❑

13. HIGH SCHOOL EDUCATION:			
NAME OF SCHOOL			
ADDRESS	CITY	STATE	ZIP CODE
DATE OF GRADUATION			
COURSE OF STUDY (E.G., COLLEGE PREP, ETC.)			
14. COLLEGE OR OTHER EDUCATION.			
NAME OF SCHOOL			
ADDRESS	CITY	STATE	ZIP CODE
DATE OF GRADUATION			
COURSE OF STUDY (E.G., COLLEGE PREP, ETC.)			
15. AURICULAR DETOXIFICATION EDUCATION AND TRAINING: PLEASE LIST EVERY SCHOOL YOU HAVE ATTENDED AND/OR RECEIVED TRAINING INCLUDING SCHOOLS NOT LOCATED WITHIN THE UNITED STATES. PLEASE USE ADDITIONAL SHEETS IF NECESSARY.			
NAME OF SCHOOL:			
ADDRESS	CITY	STATE	ZIP CODE
DATES OF ATTENDANCE		GRADUATION DATE:	
SPECIALTY (IF ANY)			
NAME OF SCHOOL:			
ADDRESS	CITY	STATE	ZIP CODE
DATES OF ATTENDANCE		GRADUATION DATE:	
SPECIALTY (IF ANY)			
NAME OF SCHOOL:			
ADDRESS	CITY	STATE	ZIP CODE
DATES OF ATTENDANCE		GRADUATION DATE:	
SPECIALITY (IF ANY)			